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SENATE

REPORT
101-508

EXTENDING TO TRIBALLY OWNED HEALTH FACILITIES THE SAME FEDERAL MEDICAL ASSISTANCE PERCENTAGE (100 PERCENT) AS IS APPLICABLE TO THOSE FACILITIES OPERATED DIRECTLY BY THE INDIAN HEALTH SERVICE

OCTOBER 5 (legislative day, OCTOBER 2), 1990.—Ordered to be printed

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Mr. INOUYE, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 2888]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2888) to extend to tribally owned health facilities the same Federal medical assistance percentage (100 percent) as is applicable to those facilities operated directly by the Indian Health Service, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

The purpose of S. 2888 is to amend Title XIX of the Social Security Act (Medicaid) in order to extend to tribally-owned health facilities the same Federal medical assistance percentage (100%) that is applicable to those facilities operated directly by the Indian Health Service.

BACKGROUND AND NEED

In 1976, Congress enacted the Indian Health Care Improvement Act ("the Act") into law in response to findings that the health status of Native Americans continued to rank far below that of the general population, and that the effectiveness of Federal programs and services were jeopardized by the low health status of the Native American people.

One of the Act's purposes was to increase the number of American Indian and Alaska Native patients being served through the use of third party resources to which they are entitled. Title IV of the Act authorizes payments through the Medicare and Medicaid programs to Indian Health Service facilities for services rendered

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to Medicare and Medicaid-eligible Indian patients. In section 402 of the Act, Congress amended section 1905(b) of the Social Security Act by setting the Federal medical assistance percentage for payments to Indian Health Service facilities at one hundred percent (100%). Thus, the Federal Government agreed to subsidize the entire cost of providing medical services to Medicaid-eligible Indian patients through Indian Health Service facilities. Congress noted in adding this provision that it would be unfair to burden state Medicaid programs with costs that normally would have been borne by the Indian Health Service, and that, with respect to matters relating to Native Americans, the Federal Government has traditionally assumed major responsibility. Under section 1905(b) of the Social Security Act, a participating facility is described as "an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization."

Unfortunately, this language has given rise to a number of conflicting interpretations concerning the actual facilities covered under the Act. Much of the controversy has centered around whether Congress ever intended to restrict the benefits of the Act to those particular health facilities which the Indian Health Service owns. The Indian Health Service has taken the position that the language in the Act only authorizes a Federal medical assistance percentage of 100% for those facilities which are, in fact, owned by the Indian Health Service. This interpretation of the Act requires that tribally-owned health facilities remain subject to the appropriate state Federal medical assistance percentage.

In a number of instances, this restrictive interpretation has led to inequitable results. For instance, rising Medicaid costs have led many states to severely restrict the number of additional Medicaid providers. Tribes that have independently sought to finance and develop health care facilities for the care and treatment of their own people have discovered that these facilities are no longer eligible for Medicaid payments. Without the availability of Medicaid payments, the operation of a health facility in Indian Country is often economically unfeasible. Thus, tribal residents are denied access to health care services in instances where an Indian Health Service facility does not already exist or where, as in the case of nursing home care, the Indian Health Service does not provide certain types of care. Since the alternative of seeking off-reservation treatment often entails the time and cost of long travel, many Native Americans simply forego the medical care they need.

If tribally-owned facilities were deemed eligible for a Federal medical assistance percentage of 100%, access to health care services could be improved. States have already indicated they will accept additional Medicaid providers as long as the new facilities will not burden them with further Medicaid costs. The extension of a Federal medical assistance percentage of 100% to tribally-owned facilities would, in areas such as nursing home care, enable tribes to implement services where none have previously existed. The extension of this percentage coverage would also reduce the disparity between Indian Health Service facilities and tribally-owned facilities, providing further incentives for Native Americans to assume responsibility for the health and well-being of their own people.

Recognizing these needs, and in keeping with the Act's original intent of elevating the health status of all Native Americans, Senator Daschle introduced S. 2888, which would extend to tribally-owned facilities a Federal medical assistance percentage of one hundred percent (100%) for health care services provided to/for Medicaid-eligible Indian patients. This amendment would provide tribes with the full scope of Medicaid coverage they were originally intended to receive.

Legislative History

S. 2888 was introduced on July 23, 1990 by Senator Daschle and was referred to the Select Committee on Indian Affairs. The bill was ordered reported by the Committee on September 12, 1990.

Summary

This bill would extend to tribally-owned health facilities a Federal medical assistance percentage of one hundred percent (100%) for health care services provided to Medicaid-eligible Indian patients. This is the same Federal medical assistance percentage that is applicable to facilities owned by the Indian Health Service.

Under the present interpretation of Title IV of the Indian Health Care Improvement Act, only those facilities owned by the Indian Health Service qualify as "Indian Health Service facilities." Accordingly, only Indian Health Service-owned facilities are authorized to receive a Federal medical assistance percentage of one hundred percent (100%) for health care services provided to Medicaid-eligible Indian patients. Health facilities owned by tribes or tribal organizations receive Medicaid payments from the state in accordance with the Federal medical assistance percentage applicable to the state in which they are located. The Federal medical assistance percentage ranges from 50% to as much as 79.65%, with the balance paid by the respective state.

Many states, however, have restricted the number of new health care providers eligible for participation in the Medicaid program because of the increased cost to the states that further Medicaid payments would involve. These restrictions tend to have the greatest impact on portions of the Native American population whose tribes and tribal organizations have undertaken the construction and operation of their own health care facilities. Indian Health Service facilities, on the other hand, have been shielded from these restrictions because they are authorized to receive a Federal medical assistance percentage of 100% for health care services provided to Medicaid-eligible Indian patients. Accordingly, states have been willing to lift Medicaid restrictions against these facilities because they will impose few additional costs upon state Medicaid programs.

S. 2888 would enable tribes and tribal organizations operating tribally-owned health facilities to avoid the state imposed restrictions upon participation in the Medicaid program by extending to them the same Federal medical assistance percentage applicable to facilities owned by the Indian Health Service. Thus, the Federal Government would pay for 100% of the reimbursements to tribally-owned health facilities for services provided to Medicaid-eligible

Indian patients. This, in turn, would reduce the states' current share of Medicaid expenditures to 0% for these same facilities. As a result, Native Americans will have better access to health care services and will be able to more fully utilize third party resources to which they are entitled.

S. 2888 would amend only section 1905(b) of the Social Security Act. S. 2888 does not attempt to alter the definition of "Indian Health Service facilities." The term "Indian Health Service facility" will continue to be defined as a facility owned by the Indian Health Service. Accordingly, other provisions in Title IV of the Indian Health Care Improvement Act remain unaffected. For example, the requirement that Indian Health Service facilities remit Medicare and Medicaid collections into a Secretarial fund in section 402(c) of the Act remains applicable only to those facilities owned by the Indian Health Service. Tribally-owned health facilities will not be subject to this requirement. The Committee also feels that it would be inequitable to require tribally-owned facilities to remit Medicare and Medicaid reimbursements to the Secretary where those collections are authorized only for the improvement of Indian Health Service facilities. Tribally-owned facilities are at present free to collect and retain Medicare and Medicaid reimbursements without forwarding them to the Secretary's fund. Once again, the Committee intends that tribes and tribal organizations should not be discouraged from assuming responsibility for the health and well-being of their own people.

Committee Recommendation and Tabulation of Vote

The Select Committee on Indian Affairs, in open business session on September 12, 1990, by a unanimous vote of a quorum present, ordered S. 2888 reported to the Senate with the recommendation that it be passed.

Section-by-Section Analysis

Section 1 amends section 1905(b) of the Social Security Act to authorize a Federal medical assistance percentage of one hundred percent (100%) to tribally-owned health facilities for health care services provided to Medicaid-eligible Indian patients. Currently, that Federal medical assistance percentage applies only to those health facilities owned by the Indian Health Service.

Section 1 does not amend the definition of "Indian Health Service facilities" as found in the Indian Health Care Improvement Act. P.L. 94-437, as amended. An "Indian Health Service facility" continues to be defined as a facility owned by the Indian Health Service. Accordingly, tribally-owned facilities will not be required to remit Medicaid payments to the Secretary's special fund referenced in section 402(c) of the Indian Health Care Improvement Act.

Cost and Budgetary Considerations

The cost estimate for S. 2888, as evaluated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 10, 1990.

Hon. TOM DASCHLE,
U.S. Senate,
Washington, DC.

DEAR SENATOR: As you requested, the Congressional Budget Office has prepared the attached cost estimate for S. 2888, an amendment to Title XIX of the Social Security Act relating to Indian health care, as introduced and referred to the Senate Select Committee on Indian Affairs on July 23, 1990.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT F. HALE
(For Robert D. Reischauer).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2888.
2. Bill title: None.
3. Bill status: As introduced and referred to the Senate Select Committee on Indian Affairs on July 23, 1990.
4. Bill purpose: To amend title XIX of the Social Security Act to extend the 100% federal Medicaid reimbursement to tribal-owned Indian health facilities.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1991	1992	1993	1994	1995
Estimated budget authority	40	45	50	60	65
Estimated outlays	40	45	50	60	65

The costs of this bill fall within budget function 550.

Basis of Estimate: S. 2888 would authorize the federal government to pay for the full cost of services provided to Medicaid-eligible Indians in facilities owned and operated by an Indian tribe or tribal organization. Under current law, the federal government pays for the total cost of services provided to Medicaid-eligible Indians in Indian health facilities owned by the Indian Health Service (IHS), regardless of whether the facilities are operated by IHS or by an Indian tribe or tribal organization. Tribally-owned Indian health facilities, however, are reimbursed by the federal government according the Federal Medical Assistance Percentage; the states in which the facilities are located are liable for the remainder of the costs, as with any other Medicaid service. This bill would transfer the state share of the Medicaid costs to the Federal government.

The cost to the federal government of this legislation would be the state share of providing service to Medicaid-eligible Indians at tribally-owned facilities. To estimate this cost, CBO examined state data gathered by the Health Care Financing Administration

(HCFA) on number of Indian recipients of Medicaid and total cost of treating those recipients. We adjusted this information in order to focus on the population of recipients likely to go to tribally-owned health facilities. First, we adjusted the data to reflect only those Indian Medicaid recipients living in IHS service areas. IHS service areas are on or near Indian reservations, areas where tribally-owned facilities would be located. Secondly, CBO adjusted the data to reflect the fact that most Indians receive inpatient care at IHS owned, or other private facilities, but not at tribally-owned facilities as there are currently only two tribally-owned hospitals. Therefore, the potential liability of the federal Medicaid program for additional inpatient costs is minimal. Next, we subtracted the total amount IHS has been reimbursed by the federal government for all non-inpatient care from the total Medicaid cost of providing outpatient and nursing home services to eligible Indians in IHS service areas. The remainder of the Medicaid costs reflects the total Medicaid costs of serving eligible Indians in tribal-owned facilities, assuming that all Medicaid-eligible Indians in IHS service areas who do not receive outpatient or nursing home care at IHS owned facilities, would receive that care at tribal-owned facilities.

The additional costs to the federal government resulting from the enactment of this legislation are estimated by applying the average state matching rate of the relevant states of 40 percent to the total Medicaid cost of providing non-inpatient services to eligible Indians in tribal-owned facilities, which is estimated at approximately $100 million. Therefore, CBO estimates that this legislation would cost the federal government $40 million in fiscal year 1991, increasing to $65 million by fiscal year 1995.

6. Estimated cost to State and local government: State governments would save approximately $40 million in fiscal year 1991, increasing to $65 million by fiscal year 1995 because they would no longer be laible for any share of the costs of services provided to Medicaid-eligible Indians in tribally-owned Indian health facilities.

7. Estimate comparison: None.

8. Provision CBO Estimate: None.

9. Estimate prepared by: Karen Graham.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

Executive Communications

Although the Committee requested the views of the United States Department of Health and Human Services on S. 2888 the Committee did not receive any statement from that Department or other agencies of the Federal Government.

Regulatory Impact Statement

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the provisions of the bill. The Committee believes that S. 2888 will have a minimal impact on regulatory and paperwork requirements.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 2888 will result in the following amendment to the Social Security Act, ch. 531, 49 Stat. 620 (1935), as amended:

SEC. 1905. (b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and that State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an [Indian Health Service facility] *Indian health facility* whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25).

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